

Telecommunications Equipment Purchase Program (TEPP) APPLICATION FOR VOUCHER

Mailing address and Fax number are below. For questions about the application or the Telecommunications Equipment Purchase Program (TEPP), you may call: (608) 274-1980 Voice, (608) 274-4448 TTY, or email TEPP@Wipfli.com. You may fill out and file your application from our website at: <http://psc.wi.gov/>

PERSONAL INFORMATION (Please print your responses.)

Applicant's Name (Last, First, Middle) (Maiden, if applicable)

Applicant's Street Address or Rural Home Address (no P.O. Boxes)

Apt. No.

City

State

ZIP Code

Telephone Number: () - - ☐ TTY ☐ Voice

Email Address:

Social Security No.: - -

Date of Birth:

DISABILITY CATEGORY (CHECK ONE)

- ☐ Hard of Hearing (Voucher Maximum \$125 with no co-payment required)
☐ Severely Hard of Hearing **or** Deaf (Voucher Maximum \$800)
☐ Speech Impaired (Voucher Maximum \$1,600)
☐ Mobility Impaired or Motion Impaired (Voucher Maximum \$1,600)
☐ Severely Hard of Hearing **or** Deaf **and** Low Vision (Voucher Maximum \$2,500)
☐ Severely Hard of Hearing **or** Deaf **and** Blind (Voucher Maximum \$7,200)

HOUSEHOLD INFORMATION

Number of people in your household: _____

*Annual household income: \$_____ (according to most recent tax return filed and including income of spouse or parent/guardian, if applicable)

**There is no income limit for TEPP. Income information will be used to determine if Severely Hard of Hearing or Deaf applicants are eligible for assistance which can pay the \$100 co-payment.*

Have you previously received assistance from: TEPP? TAP?

- ☐ Yes ☐ Yes
☐ No ☐ No
☐ Don't recall ☐ Don't recall

SELF-CERTIFICATION AND SIGNATURE

I certify that I have a disability in the category checked above that limits or curtails my access to or use of telecommunications services. Equipment to be purchased with this voucher is necessary for me to effectively access telecommunications services.

I understand that any deliberate fraud or misuse of this program will result in legal action taken by the State of Wisconsin. I understand that I need to make a \$100 co-payment when I purchase the equipment unless I qualify for TAP assistance or checked the Hard of Hearing category.

THESE STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Applicant Signature or Guardian Signature (check box)

☐ Guardian

Date

MAIL APPLICATION TO:

USF Fund Administrator, c/o Wipfli LLP
P.O. Box 8700, Madison, WI 53708-8700

OR FAX APPLICATION TO:

USF Fund Administrator, (608) 274-8085

The information requested on this form is authorized for collection to administer the Universal Service Fund pursuant to s. 196.218, Stats., and PSC 160.71, Wis. Adm. Code. The information collected is used to determine eligibility for the Universal Service Fund programs of the Public Service Commission of Wisconsin. Completion of this form is voluntary; however, failure to furnish the requested information may result in denial of eligibility for support under these programs. Personally identifiable information collected on this form is not likely to be used for purposes unrelated to the Universal Service Fund programs.

Applications are processed in the order they are received. Vouchers will be issued on a first come, first served basis in compliance with rules governing the Universal Service Fund. Specific limitations will apply as identified in PSC §160.07 and 160.071, relating to funding, definition of disability and voucher amount. Voucher recipients are responsible for the first \$100 of the equipment purchased, unless they qualify for TAP assistance or applied in the Hard of Hearing Category. Voucher recipients are also responsible for any additional amount exceeding the maximum value of the voucher plus the co-payment.

THIS SECTION FOR OFFICE USE ONLY

TEPP

Date received: _____

☐ Eligible

☐ Ineligible: Reason: _____

USF Administer and date: _____

TAP

☐ Eligible

☐ Ineligible: Reason: _____